

Sexually Transmitted Infections

Editorials

Chancroid in the United Kingdom

Chancroid is a genital ulcer infection caused by *Haemophilus ducreyi* and is found mainly in developing countries. The highest prevalences are reported from southern, central, and eastern Africa. The importance of chancroid as a risk factor for heterosexual HIV transmission in developing countries is well recognised.^{1,2} Chancroid is also associated with an increased risk of HIV in the United States.^{3,4}

Significant outbreaks of chancroid have been reported in recent times in Canada and the United States.^{5,6} These epidemics have usually been associated with commercial sex work. Recent outbreaks have been associated with syphilis, an increased risk of HIV infection, and the use of crack cocaine.^{7,8} Control measures have centred around improved surveillance and contact tracing. The development of the Roche multiplex polymerase chain reaction (M-PCR) assay for *H ducreyi* has enabled the diagnosis of chancroid to be made in settings where ready access to culture techniques for *H ducreyi* was previously unavailable. In a recent 10 city study, chancroid was confirmed in 12% of genital ulcers in Chicago and 20% in Memphis.⁹

In the United Kingdom, the reported number of cases of chancroid in recent years has never reached epidemic proportions. Currently, cases are reported to the Communicable Disease Surveillance Centre through the KC 60 returns from genitourinary clinics throughout the country. Chancroid is included under the C1-C3 coding which also includes cases of lymphogranuloma venereum (LGV) and donovanosis. The number of cases of these conditions reported between 1975–95 is shown in figure 1.¹⁰ In most years 60–120 cases were reported. Before 1989 these conditions were reported separately with chancroid included under the C1 code.¹¹ A peak of 125 (88 men, 37 women) cases of chancroid was reported in 1982 and probably reflects the large numbers of cases diagnosed in Sheffield.¹² Outside of these clinic returns, reports of chancroid in the medical literature in the United Kingdom are

few, mainly in the north of England—in Sheffield,¹² Manchester,¹³ and Liverpool.¹⁴

The chancroid cases reported in Sheffield have been much debated and merit further comment. These cases were unusual in that:

- (1) the organisms identified as *H ducreyi* were β lactamase negative
- (2) 38 of the 46 cases also had proved genital herpes; the others had either a history of genital herpes or another specific cause of genital ulceration
- (3) in only two instances had there been sexual contact between two cases found to have chancroid
- (4) no buboes were reported
- (5) the sex distribution was equal
- (6) *H ducreyi* was isolated from three men after their ulcers had completely healed.

The overall impression was that the organisms isolated in Sheffield had reduced virulence and low pathogenicity and were secondary invaders of pre-existing genital lesions. Others have questioned the efficacy of the Sheffield medium used to grow *H ducreyi* in Sheffield.¹⁵ Using samples from Nairobi, Kenya, MacDonald *et al* were only able to grow *H ducreyi* on one sample using Sheffield media with horse blood compared with 57 (66%) samples using supplemented gonococcal base or supplemented Muller-Hinton.¹⁶

Recently, an outbreak of syphilis was identified in Bristol, an average sized English city.¹⁷ This epidemic mainly affected informal female sex workers with low condom use, their clients, and members of the Afro-Caribbean community. A further risk factor for some infected cases was crack cocaine use (P Horner, personal communication). Could an outbreak of chancroid occur in the United Kingdom mirroring the US experience in which there was considerable overlap in the client risk profile for outbreaks of syphilis and chancroid? How should clinics be best prepared so that cases of chancroid can be identified and treated without undue delay?

Firstly, clinicians will need to maintain a high index of clinical suspicion. Although chancroid does not always present with classic textbook appearances, lesions with a pale yellow shallow base, irregular edge, and associated inguinal lymphadenopathy should be viewed as possible cases. Ulcers are more common in uncircumcised men and are usually painful. In women, ulcers are usually external and involve the labia and introitus. Inguinal buboes are not unusual. In women there is still an issue about the importance or otherwise of asymptomatic carriage of *H ducreyi*. Female sex workers in both Nairobi¹⁸ and the Gambia¹⁹ have been identified with asymptomatic carriage of *H ducreyi* although the proportions infected were very low.

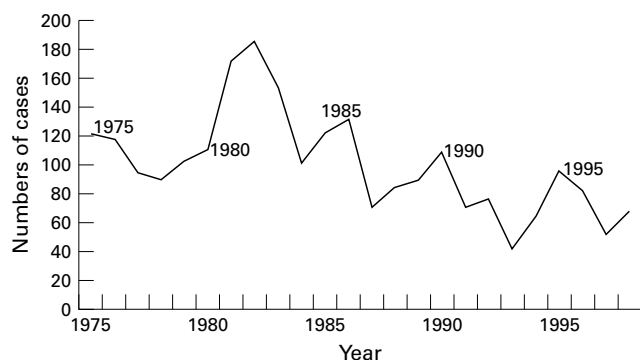


Figure 1 New diagnoses of chancroid, LGV, and donovanosis in the United Kingdom in men and women 1975–95.

Secondly, a travel history is important. The cases identified in the reports from Manchester and Liverpool^{13 14} were associated with travel to countries where chancroid is endemic. If lessons are to be learnt from recent experience in the United States where there was a significant association between outbreaks of syphilis, chancroid, and the use of crack cocaine, a high index of suspicion for chancroid is justified for genital ulcers in Afro-Caribbeans given their connection in the Bristol syphilis outbreak and the known endemicity of both syphilis and chancroid in the Caribbean.²⁰ Also, travellers or recent immigrants with genital ulcers from southern African countries, where the United Kingdom still has close Commonwealth ties, should be considered to be at risk of chancroid, particularly if there is a history of unprotected commercial sex.

Because of its importance in facilitating heterosexual HIV transmission, opportunities to improve surveillance for chancroid should be sought. The KC 60 coding system is due to undergo revision soon and it would surely not be a retrograde step to revert to the pre-1989 system whereby chancroid was reported under the C1 coding, LGV as C2, and donovanosis as C3.

Ideally, patients with chancroid and their sexual contacts are best treated at their first attendance. Currently the most cost effective options are either a single dose of ciprofloxacin 500 mg or erythromycin 500 mg three times daily for 7 days.²¹ However, if it is thought expedient to try and confirm the diagnosis of chancroid by culture, it may be necessary to bring patients back when suitable culture media are available.

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The COPE Report 1999

Hitherto, there has been a lack of a coordinated approach by editors of scientific and medical journals to breaches of research and publication ethics. The publication in this issue of the journal of the guidelines on good publication practice developed by the Committee on Publication Ethics (COPE) is therefore most welcome. Consensus has been reached on what constitutes good research and the guidelines on study design, ethical approval, and data analysis are sensible and clear. In any case, all researchers should already follow these principles. For many years, there has been controversy on authorship, and guidance is given on avoidance of conflict over this issue. The duty of all authors to take public responsibility for the content of their paper is rightly emphasised. Conflicts of interest are not confined to the authors of papers, and editors and reviewers must ensure that any relevant conflict of interest is disclosed; again sound guidance is given in the report. Guidelines are also available on peer review and greater transparency by journals of their review, selection, and appeal processes is suggested. Ultimately, this can only benefit authors. Plagiarism and redundant publication are issues with which editors are only too familiar and, in some cases, these unethical practices can be difficult to identify. Advice to authors on how to avoid possible misconduct is

given in the report. Most editors are well aware of their duties, but it is good to see these defined here. The mass media are becoming much more concerned with biomedical research, and the guidelines on media relations are timely.

Unfortunately, breaches of research and publication ethics occur, and there have been several recent, celebrated cases. It is clear that the authors of the report have given much thought to some of the thorny issues surrounding the investigation of suspected breaches, and their guidance to editors is very clear. The mechanism for implementation of the guidelines for dealing with serious misconduct, however, is not entirely clear. For example, there does not appear to be a forum for the author(s) suspected of misconduct to rescind the allegations. With the possible grave consequences of an investigation of this nature, future refinements to the guidelines may be required.

As a former editor of the journal, I would have greatly appreciated access to guidelines such as these when considering difficult issues, and I feel that all editors should endorse this report.

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Journal ombudsman